TIERNEY CHIROPRACTIC

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Automobile Accident Questionnaire

Name: _____ Date of Injury:_____

Type of Accident/Impact Location:

☐ Head on: Left Right Straight ☐ Rear end: Left Right Straight
☐ Broadside collision ("T-Bone"): Left Right Front Mid Back

☐ Other _____

Vehicle Status: ☐Drivable ☐Towed/repairable ☐ Totaled ☐Mirror(s) broken/bent ☐ Seat beat broken
Police on scene?: ☐ Yes ☐ No

Details of impact:
What time of day: ☐Day ☐Night ☐Dawn ☐Dusk Road Condition: ☐Dry ☐Damp ☐Wet Ice
Were you: ☐Driver ☐Passenger ☐Front Seat ☐Back Seat ☐Pedestrian ☐Bicyclist
Other: ☐ Seat belt fastened ☐ Seat Belt over shoulder ☐ Airbag deployed ☐ Braced for impact
Was the vehicle in motion prior to impact? ☐ Yes ☐ No If yes, how fast _____mph
Were you able to apply brakes before impact? ☐ Yes ☐ No
Head position: ☐ Left ☐ Right ☐ Straight ☐ Head turned looking behind
Hand Position: ☐ One on Wheel ☐ Two on Wheel ☐ Other_____
Sitting Position: ☐ Knees left ☐ Knees Right ☐ Knees Straight ☐ Feet up on dash
Were there other people in the vehicle with you: ☐ Yes ☐ No Wearing Glass? ☐ Yes ☐ No

Head Movement: Did You Hit Your Head: ☐Yes ☐No
If yes, what did your head hit? ☐Rear head rest ☐Flying object ☐Windshield ☐Steering wheel
☐ Door frame ☐Side window ☐ Other _____

Were you knocked unconscious? ☐ Yes ☐ No If so, how long? _____

Body Movement: Did Your Body Hit Anything: ☐ Yes ☐ No If yes, which body part:
☐ Knee ☐ Leg ☐ Ankle ☐ Foot ☐ Hip ☐ Jaw ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

What did your body hit? _____

Did You Feel Your Body Go: ☐Forward and Back ☐ Back and forward ☐ Side to Side ☐ Spinning
Did your vehicle strike other objects or vehicles as a result of the accident? ☐ Yes ☐ No If Yes, Explain

_____

Symptoms from accident: ☐Headache ☐Dizzy ☐Disoriented ☐ Shock ☐ Neck pain/stiff ☐ Jaw pain

☐ Back pain/stiff ☐ Numbness/Tingling ☐ Other _____

1st symptom appeared _____ (min or hrs). after accident

After Accident:
Went to _____ (location) on _____(date/time)

Taken to this location by _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No Whom?_____

What type of treatment/self-treatment did you receive/do? _____

Have you been working since the accident?: ☐ Yes ☐ No If yes, date returned to work: _____
Are your work activities restricted as a result of the accident? ☐ Yes ☐ No Work Days Missed: _____

What complaints in the involved area did you have prior to the accident? _____

Insurance: Insurance company: _____

Agent Name _____ Phone_____

Address_____

Policy and/or Claim Number:_____

Patient Signature_____Date_____